issuer's request) a written authorization for the issuer to request a certificate on behalf of the individual, and cooperating in efforts to determine the validity of the corroborating evidence and the dates of creditable coverage. While an issuer may refuse to credit coverage if the individual fails to cooperate with the issuer's efforts to verify coverage, the issuer may not consider an individual's inability to obtain a certificate to be evidence of the absence of creditable coverage.

(ii) *Documents.* Documents that may establish creditable coverage (and waiting periods or affiliation periods) in the absence of a certificate include explanations of benefit claims (EOB) or other correspondence from a plan or issuer indicating coverage, pay stubs showing a payroll deduction for health coverage, a health insurance identification card, a certificate of coverage under a group health policy, records from medical care providers indicating health coverage, third party statements verifying periods of coverage, and any other relevant documents that evidence periods of health coverage.

(iii) *Other evidence.* Creditable coverage (and waiting period or affiliation period information) may be established through means other than documentation, such as by a telephone call from the issuer to a third party verifying creditable coverage.

(3) *Demonstrating dependent status.* If, in the course of providing evidence (including a certificate) of creditable coverage, an individual is required to demonstrate dependent status, the issuer must treat the individual as having furnished a certificate showing the dependent status if the individual attests to the dependency and the period of the status and the individual cooperates with the issuer's efforts to verify the dependent status.

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[62 FR 16998, Apr. 8, 1997; 62 FR 31696, June 10, 1997, as amended at 62 FR 35906, July 2, 1997]

§ 148.126 Determination of an eligible individual.

(a) *General rule.* Each issuer offering health insurance coverage in the individual market is responsible for determining whether an applicant for coverage is an eligible individual as defined in § 148.103.

(b) *Specific requirements.* (1) The issuer must exercise reasonable diligence in making this determination.

(2) The issuer must promptly determine whether an applicant is an eligible individual.

(3) If an issuer determines that an individual is an eligible individual, the issuer must promptly issue a policy to that individual.

(c) *Insufficient information*—(1) *General rule.* If the information presented in or with an application is substantially insufficient for the issuer to make the determination described in paragraph (b)(2) of this section, the issuer may immediately request additional information from the individual, and must act promptly to make its determination after receipt of the requested information

(2) *Failure to provide a certification of creditable coverage.* If an entity fails to provide the certificate that is required under this part or part 146 of this subchapter to the applicant, the issuer is subject to the procedures set forth in § 148.124(d)(1) concerning an individual's right to demonstrate creditable coverage.

[62 FR 17000, Apr. 8, 1997]

EFFECTIVE DATE NOTE: At 62 FR 17000, Apr. 8, 1997, § 148.126 was added. This section contains information collection and recordkeeping requirements and will not become effective until approval has been given by the Office of Management and Budget.

§ 148.128 State flexibility in individual market reforms—alternative mechanisms.

(a) *Waiver of requirements.* The requirements of § 148.120, which set forth Federal requirements for guaranteed availability in the individual market, do not apply in a State that implements an acceptable alternative mechanism in accordance with the following criteria:

(1) The alternative mechanism meets the following conditions:

(i) Offers health insurance coverage to all eligible individuals.

(ii) Prohibits imposing preexisting condition exclusions and affiliation periods for coverage of an eligible individual.

(iii) Offers an eligible individual a choice of coverage that includes at least one policy form of coverage that is comparable to either one of the following:

(A) Comprehensive coverage offered in the individual market in the State.

(B) A standard option of coverage available under the group or individual health insurance laws of the State.

(2) The State is implementing one of the following provisions relating to risk:

(i) One of the following model acts, as adopted by the NAIC on June 3, 1996, but only if the model has been revised in State regulations to meet all of the requirements of this part and title 27 of the PHS Act.

(A) The Small Employer and Individual Health Insurance Availability Model Act to the extent it applies to individual health insurance coverage.

(B) The Individual Health Insurance Portability Model Act.

(ii) A qualified high risk pool, which, for purposes of this section, is a high risk pool that meets the following conditions:

(A) Provides to all eligible individuals health insurance coverage (or comparable coverage) that does not impose any preexisting condition exclusion or affiliation periods for coverage of an eligible individual.

(B) Provides for premium rates and covered benefits for the coverage consistent with standards included in the NAIC Model Health Plan for Uninsurable Individuals Act (as in effect as of August 21, 1996), but only if the model has been revised in State regulations to meet all of the requirements of this part and title 27 of the PHS Act.

(iii) One of the following mechanisms:

(A) Any other mechanism that provides for risk adjustment, risk spreading, or a risk-spreading mechanism (among issuers or policies of an issuer) or otherwise provides for some financial subsidization for eligible individuals, including through assistance to participating issuers.

(B) A mechanism that provides a choice for each eligible individual of all individual health insurance coverage otherwise available.

(b) *Permissible forms of mechanisms.* A private or public individual health insurance mechanism (such as a health insurance coverage pool or program, a mandatory group conversion policy, guaranteed issue of one or more plans of individual health insurance coverage, or open enrollment by one or more health insurance issuers), or combination of these mechanisms, that is designed to provide access to health benefits for individuals in the individual market in the State, in accordance with this section, may constitute an acceptable alternative mechanism.

(c) *Establishing an acceptable alternative mechanism—transition rules.* CMS presumes a State to be implementing an acceptable alternative mechanism as of July 1, 1997 if the following conditions are met:

(1) By not later than April 1, 1997, as evidenced by a postmark date, or other such date, the chief executive officer of the State takes the following actions:

(i) Notifies CMS that the State has enacted or intends to enact by not later than January 1, 1998 (unless it is a State described in paragraph (d) of this section), any legislation necessary to provide for the implementation of a mechanism reasonably designed to be an acceptable alternative mechanism as of January 1, 1998.

(ii) Provides CMS with the information necessary to review the mechanism and its implementation (or proposed implementation).

(2) CMS has not made a determination, in accordance with the procedure in paragraph (e)(4) of this section, that the State will not be implementing a mechanism reasonably designed to be an acceptable alternative mechanism as of January 1, 1998.

(d) *Delay permitted for certain States.* If a State notifies CMS that its legislature is not meeting in a regular session between August 21, 1996 and August 20, 1997, CMS continues to presume until July 1, 1998 that the State is implementing an acceptable alternative mechanism, if the chief executive officer of the State takes the following actions:

(1) Notifies CMS by April 1, 1997, that the State intends to submit an alternative mechanism and intends to enact any necessary legislation to provide for

the implementation of an acceptable alternative mechanism as of July 1, 1998.

(2) Notifies CMS by April 1, 1998, that the State has enacted any necessary legislation to provide for the implementation of an acceptable alternative mechanism as of July 1, 1998.

(3) Provides CMS with the information necessary to review the mechanism and its implementation (or proposed implementation).

(e) *Submitting an alternative mechanism after April 1, 1997*—(1) *Notice with information.* A State that wishes to implement an acceptable alternative mechanism must take the following actions:

(i) Notify CMS that it has enacted legislation necessary to provide for the implementation of a mechanism reasonably designed to be an acceptable alternative mechanism, and

(ii) Provide CMS with the information necessary for CMS to review the mechanism and its implementation (or proposed implementation).

(2) *An acceptable alternative mechanism.* If the State takes the actions described in paragraph (e)(1) of this section, the mechanism is considered to be an acceptable alternative mechanism unless CMS makes a preliminary determination (under paragraph (e)(4)(i) of this section), within the review period (defined in paragraph (e)(3) of this section), that the mechanism is not an acceptable alternative mechanism.

(3) *Review period*—(i) *General.* The review period begins on the date the State's notice and information are received by CMS, and ends 90 days later, not counting any days during which the review period is suspended under paragraph (e)(3)(ii) of this section.

(ii) *Suspension of review period.* During any review period, if CMS notifies the State of the need for additional information or further discussion on its submission, CMS suspends the review period until the State provides the necessary information.

(4) *Determination by CMS*—(i) *Preliminary determination.* If CMS finds after reviewing the submitted information, and after consultation with the chief executive officer of the State and the chief insurance regulatory official of the State, that the mechanism is not an acceptable alternative mechanism, CMS takes the following actions:

(A) Notifies the State, in writing, of the preliminary determination.

(B) Informs the State that if it fails to implement an acceptable alternative mechanism, the Federal guaranteed availability provisions of §148.120 will take effect.

(C) Permits the State a reasonable opportunity to modify the mechanism (or to adopt another mechanism).

(ii) *Final determination.* If, after providing notice and a reasonable opportunity for the State to modify its mechanism, CMS makes a final determination that the design of the State's alternative mechanism is not acceptable or that the State is not substantially enforcing an acceptable alternative mechanism, CMS notifies the State in writing of the following:

(A) CMS's final determination.

(B) That the requirements of §148.120 concerning guaranteed availability apply to health insurance coverage offered in the individual market in the State as of a date specified in the notice from CMS.

(iii) *State request for early notice.* A State may request that CMS notify the State before the end of the review period if CMS is not making a preliminary determination.

(5) *Effective date.* If CMS does not make a preliminary determination within the review period, the acceptable alternative mechanism is effective 90 days after the end of the 90-day review period described in paragraph (e)(3)(i) of this section.

(f) *Continued application.* A State alternative mechanism may continue to be presumed to be acceptable, if the State provides information to CMS that meets the following requirements:

(1) If the State makes a significant change to its alternative mechanism, it provides the information before making a change.

(2) Every 3 years from the later of implementing the alternative mechanism or implementing a significant change, it provides CMS with information.

(g) *Review criteria.* CMS reviews each State's submission to determine whether it addresses all of the following requirements:

(1) Is the mechanism reasonably designed to provide all eligible individuals with a choice of health insurance coverage?

(2) Does the choice offered to eligible individuals include at least one policy form that meets one of the following requirements?

(i) Is the policy form comparable to comprehensive health insurance coverage offered in the individual market in the State?

(ii) Is the policy form comparable to a standard option of coverage available under the group or individual health insurance laws of the State?

(3) Does the mechanism prohibit preexisting condition exclusions for all eligible individuals?

(4) Is the State implementing one of the following:

(i) The NAIC Small Employer and Individual Health Insurance Availability Model Act (Availability Model), adopted on June 3, 1996, revised to reflect HIPAA requirements.

(ii) The Individual Health Insurance Portability Model Act (Portability Model), adopted on June 3, 1996, revised to reflect HIPAA requirements.

(iii) A qualified high-risk pool that provides eligible individuals health insurance or comparable coverage without a preexisting condition exclusion, and with premiums and benefits consistent with the NAIC Model Health Plan for Uninsurable Individuals Act (as in effect August 21, 1996), revised to reflect HIPAA requirements.

(iv) A mechanism that provides for risk spreading or provides eligible individuals with a choice of all available individual health insurance coverage.

(5) Has the State enacted all legislation necessary for implementing the alternative mechanism?

(6) If the State has not enacted all legislation necessary for implementing the alternative mechanism, will the necessary legislation be enacted by January 1, 1998?

(h) *Limitation of CMS's authority*. CMS does not make a preliminary or final determination on any basis other than that a mechanism is not considered an acceptable alternative mechanism or is not being implemented.

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Subpart C—Requirements Related to Benefits

§ 148.170 Standards relating to benefits for mothers and newborns.

(a) *Hospital length of stay*—(1) *General rule*. Except as provided in paragraph (a)(5) of this section, an issuer offering health insurance coverage in the individual market that provides benefits for a hospital length of stay in connection with childbirth for a mother or her newborn may not restrict benefits for the stay to less than—

(i) 48 hours following a vaginal delivery; or

(ii) 96 hours following a delivery by cesarean section.

(2) *When stay begins*—(i) *Delivery in a hospital*. If delivery occurs in a hospital, the hospital length of stay for the mother or newborn child begins at the time of delivery (or in the case of multiple births, at the time of the last delivery).

(ii) *Delivery outside a hospital*. If delivery occurs outside a hospital, the hospital length of stay begins at the time the mother or newborn is admitted as a hospital inpatient in connection with childbirth. The determination of whether an admission is in connection with childbirth is a medical decision to be made by the attending provider.

(3) *Examples*. The rules of paragraphs (a)(1) and (a)(2) of this section are illustrated by the following examples. In each example, the issuer provides benefits for hospital lengths of stay in connection with childbirth and is subject to the requirements of this section, as follows:

Example 1. (i) A pregnant woman covered under a policy issued in the individual market goes into labor and is admitted to the hospital at 10 p.m. on June 11. She gives birth by vaginal delivery at 6 a.m. on June 12.

(ii) In this *Example 1*, the 48-hour period described in paragraph (a)(1)(i) of this section ends at 6 a.m. on June 14.